reviews

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Family Violence in Primary Care

Eds Stephen Amiel, Iona Heath

Oxford University Press, £32.50, pp 442
ISBN 0 19 262828 3

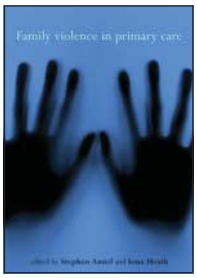
Rating: ★★★

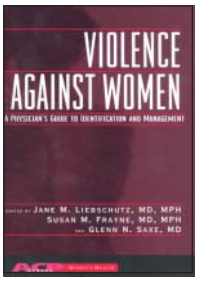
Violence Against Women: A Physician's Guide to Identification and Management

Eds Jane M Liebschutz, Susan M Frayne, Glenn N Saxe

American College of Physicians, $30, pp 368
ISBN 1 930513 11 9
www.acponline.org/catalog/books/viol_women.htm

Rating: ★★★





In 1985 US surgeon general C Everett Koop declared domestic violence the biggest public health crisis of the decade. In 1994 the United Nations recognised violence against women as a human rights abuse. In the late 1990s national surveys in Canada and the United States reported that a third of women had been physically assaulted by an intimate partner, putting them at risk of injury, a range of physical and emotional health problems, and death. In 2002 a World Health Organization report on violence and health said that up to 70% of female murder victims were killed by their partners or former partners.

Despite this, the healthcare system's role in alleviating violence against women has a short history. Decades of advocacy and scholarship, particularly in north America but also in the United Kingdom, have revealed the largely hurtful rather than helpful practices of health care: dismissive or disbelieving treatment of women, victim blaming, and prescribing psychiatric drugs rather than offering support and counselling.

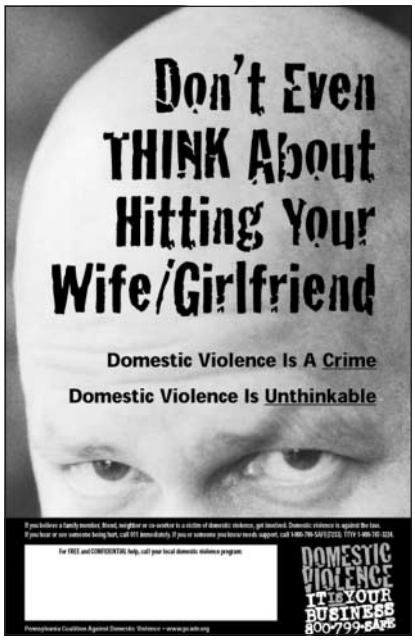
Dozens of professional associations now issue guidelines about how best to identify and respond to domestic violence. These guidelines are based on the understanding that violence towards women is mostly perpetrated by men that they know; that such violence affects women from all social and ethnic groups; that it results in potentially serious health consequences; and that most women have contact with health services, which creates an opportunity for intervention and assistance.

However, domestic violence poses enormous challenges for healthcare providers. Doctors complain about women's vague presentations, time constraints, and lack of training, and express concern that women appear reluctant to take action—for example, they fail to leave the abusive relationship or resist charging the perpetrator. There are also difficulties when the same practitioner cares for both the victim and perpetrator. Doctors worry that asking about violence will open an unmanageable "Pandora's box."

Perhaps the biggest challenge is to convince practitioners that their role is important. Interventions for violence are not amenable to randomised controlled trials and the health effects of violence do not respond to drug treatments. The lack of "evidence" of treatment efficacy has translated into an assumption that interventions do not work. Medical journals have contested the appropriateness of universal screening (*BMJ* 2002;325:314, this issue, and the *Journal of the American Medical Association* 2003;289:589-600). The debate continues about whether the proper outcomes are being studied, whether women are harmed by healthcare interventions, and what kind of training and support providers need to implement screening. Most studies have failed to ask women themselves what they want or what works. And there has been little acknowledgment that doctors and nurses might be victims or perpetrators.

Family Violence in Primary Care, a collection of essays by UK based practitioners and scholars, emphasises the opportunities that exist in general practice, where long term relationships between the provider and patient allow sensitive topics to be discussed. Its inclusion of the myriad of acts that comprise family violence—child abuse, domestic violence, and elder abuse—is ambitious and inevitably means that certain topics are diluted. A rather obvious omission is sexual assault (or marital rape), estimated to occur in up to a half of abusive relationships.

The book is wide ranging, though, dipping into sociological and psychological theories of the causes of family violence, and mapping the epidemiology of its various forms. Placing in historical and social context the range of issues facing general practitioners, the book deftly argues that family violence results from imbalances of power.



A poster from a US campaign

Violence Against Women: A Physician's Guide to Identification and Management takes a more clinical approach, geared toward the American experience and health system. It offers specific protocols for screening and making referrals to mental health and social services. It covers sexual assault examinations and the special needs of women with disabilities, women of colour, and lesbians. Several clinical vignettes bring these issues alive. The book emphasises the doctor's role in promoting individual patient empowerment rather than broader social change.

The value in both these books is their educational material, which serves to dispel stereotypes. Domestic violence is not an isolated event, but often increases in severity and intensity over the course of a relationship. Women may not respond to healthcare interventions in a straightforward way because they fear retaliation for disclosure, being judged, or having their privacy compromised. They may not leave the abusive relationship according to the doctor's plan because they worry about their children's safety, are economically dependent on their partners, experience cultural or family pressure to remain, or simply have nowhere else to go. These books remind us that women are both victims and survivors.

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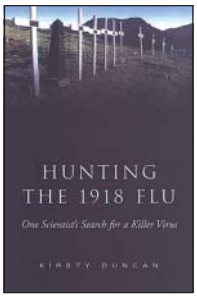
Hunting the 1918 Flu: One Scientist's Search for a Killer Virus

Kirsty Duncan



University of Toronto Press, £22.50/US$35, pp 297
ISBN 0 8020 8748 5

Rating: ★★

Kirsty Duncan, a professor of medical geography at the University of Toronto, has written about a 1998 expedition to retrieve tissues from people buried in Spitzbergen, Norway, who were killed by the 1918 flu pandemic.

In three waves, the pandemic raged in every continent except Antarctica. It is estimated to have killed 20 to 40 million people and it is well described here in a 22 page introductory review. Fifteen years after the pandemic, Christopher Andrews and Wilson Smith, at the National Institute for Medical Research (NIMR) at Mill Hill in Britain, isolated the first human influenza virus, which was found to spread by airborne droplets.

Duncan wondered whether the virus that caused the 1918 pandemic could have survived in the permafrost at Spitzbergen, where seven miners, victims of the flu, lay buried in graves 70 years old. If so, then the whole or the fragmented virus could be sequenced, allowing a relationship with encephalitis lethargica (von Economo's disease) to be explored, and also enabling a vaccine to be made.

After two and a half years of preliminary study, Duncan found that the US army had mounted such an expedition in 1951. The findings were classified but the results were negative. Dr Albert McKee had also searched for the flu virus on the Seward peninsula in Alaska. In 1966 the Norwegian government had received 146 proposals from 17 nations.

Eventually Duncan successfully put together a research team and plan that was accepted by the Norwegian government. She then learnt that Dr Jeffrey Taubenberger had successfully sequenced archival fragments analysed from paraffin-embedded tissues of 1918 vintage flu victims from the US Army Institute of Pathology. His work was one of the top 100 science stories of 1977. She promptly invited him to join her team.

Duncan's aim was "to sequence the 1918 influenza virus and not to obtain viable virus." A setback occurred when team members from the Centers for Disease Control in Atlanta departed, citing advances in archival material that made them withdraw. They were replaced by Sir John Skehel, director of the NIMR at Mill Hill and a former director of the World Influenza Centre in London.

A further setback occurred in 1998 when a student of Albert McKee from 1951 pre-emped the expedition by bringing back tissue samples in one week, without any bioprotection, which he felt to be unnecessary. The samples were from a mass grave in Brevig Mission, Alaska, which lost 85% of its people in a single week in 1918.

Duncan's expedition retrieved short fragments of the virus, recovered from many organs other than the lungs, suggesting that the flu infection became systemic in its victims. No clear cut conclusion was reached after laboratory analysis of the samples, and here lies opportunity for the future.

Meanwhile, this book is either a cautionary tale or a medical detective story about a gallant effort by a team of intrepid researchers.

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Animal

A play written by Kay Adshead

Soho Theatre, London W1, until 27 September
For details about performances and future tour dates see www.theredroom.org.uk

Rating: ★★★

Animal is a play about anger management. One of its three characters, Pongo, has been living on the streets for 30 years and has volunteered to take part in a trial to test a new drug for anger management and riot control. Dr Lee is an aspiring psychiatrist with designs on the success of the new drug, TR14 (later known as Tranqton). And Elmo is a compassionate psychiatric nurse who has his own problems with anger.

The play takes place inside a beautiful house, at the heart of a London park. England is at war and politically unstable. Pharmaceutica, the fictitious drug company that is holding the trial, is desperate to get the drug licensed and preys upon the vulnerable. It is not so worried about the harm that the drug is doing to people like Pongo.

The play begins, some way into Pongo's participation in the trial, with a calm conversation between him and his psychiatrist. They chatter about a brass band that they can hear in the park outside, the psychiatrist's husband, and her motherhood. Pongo, it seems, is well on his way to getting better. However, he flinches when Dr Lee innocently touches him, a response that calls into question the idea that he is almost well. The scene ends with Pongo in anguish.

Pongo's wellbeing is the subject of debate throughout the play. Dr Lee believes that she has observed tremendous progress, while Elmo becomes disillusioned and questions the morality of the trial. He believes that any progress in Pongo results from talking and not from the drug.

Despite the fairly typical view that the play gives of the psychiatric institution (there are psychiatric stereotypes aplenty), this play puts a fresh slant on the dramatic portrayal of psychiatry. Previously the depiction of the medical management of psychiatric patients (such as in *One Flew Over The Cuckoo's Nest*) has tended to centre on the exercise of control by power-crazy medical teams. In *Animal*, however, the motivation for treatment is financial. The play is strongly political and is littered with references to the wonderful services (such as housing complexes for the patients on leaving the trial) that Pharmaceutica has funded.

***Animal*: an enjoyable morality tale**

Animal is more than just a political satire: it is also a play of psychological depth. Elmo harbours deep-seated anger and works as a part time stand-up comedian. Although he appears a humanitarian at heart and is sickened by his recent participation in a disastrous riot, he displays misogynous tendencies. Dr Lee is not all she is cracked up to be; when Pongo is found cradling her baby she becomes uncontrollable. Pongo senses her anguish and realises that she would do anything to get her baby back. He turns the tables on her and asks about *her* past.

The play, which ends unpredictably, is immensely enjoyable. This is a morality tale that sheds light on the ethics of current clinical research.

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Items reviewed are rated on a 4 star scale (4=excellent)

NETLINES

● Misleading or just plain fraudulent health claims abound in cyberspace. One United Kingdom based family doctor has made a stand and developed a website that investigates and exposes internet health fraud and spam (www.dr-fraud.org). Primarily aimed at the general public, but of interest to the health professional, the site highlights common examples of email spam offering services such as penis enlargement. Suggested methods and strategies to deter these actions include naming and shaming. There are also links to other potential helping agencies.

● The widely used search engine google (www.google.com) has spawned many additional services over the years. One that is particularly suited to medicine is the google glossary (http://labs.google.com/glossary), an online dictionary that can explain words, acronyms, or even phrases. As with the rest of the google family, there is a minimalist style to the page.

● Anyone wanting to learn more about hepatitis C might be interested in a free online training course from the US Centers for Disease Control (www.cdc.gov/ncidod/diseases/hepatitis/C_Training/edu/Info/default.htm). Participants can find their way through the various course components, such as epidemiology, and screening and diagnostic tests, by clicking on the left hand column and working their way down. With a number of study questions thrown in (answers are provided) this is a great way to learn.

● The web is an excellent place on which to publish a database. A global audience can access the database's contents and it can be regularly and easily updated. www.pneumotox.com is a fine example of such a database. It features drugs that can cause lung disease, and, as with all good databases, there are different ways of interrogating the resource. You can either name the drug or input the disease pattern. There are also versions in French and Spanish and a printable list of all the drugs in the database.

● From Anton Chekhov to *BMJ* Soundings author Colin Douglas, many doctors have chosen to try their hand at writing fiction. A page on the BMA's website lists writers past and present who have also been medically qualified (www.bma.org.uk/ap.nsf/Content/LIBDoctorWriters). Each entry carries a short description of the writer and some entries have a web link to a more detailed site. This page is ideal for a quick but enjoyable read and provides potential material for a quiz or, perhaps, for dropping into a conversation to appear more widely read!

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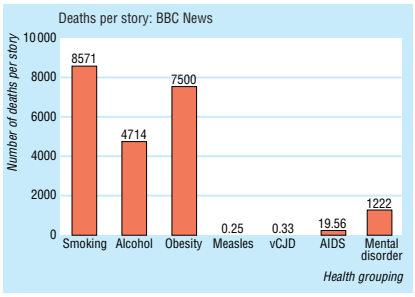
We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

News skews health priorities, study claims



How many people have to die from a disease or condition before it merits a news story on the BBC? The answer, says a new report published this week, is 0.33 people from variant Creutzfeldt-Jakob disease (vCJD) but 8571 people from smoking. The numbers of alcohol and obesity related deaths necessary to warrant news coverage are equally high—at 4714 and 7500 respectively.

The report, by think-tank the King's Fund, claims that news values are distorting health priorities. Although the deaths-per-news-story analysis is meant as no more than a crude measure designed to provoke debate about media health coverage, it gives some idea of how news reports on relatively small or unproven risks—such as bovine spongiform encephalopathy (BSE) and the MMR (measles, mumps, and rubella) vaccine—vastly outweigh reports on "major killers," such as obesity.

This deaths-per-news-story analysis reveals a similar pattern in newspaper news. It takes 4444 deaths from smoking, 846 from alcohol, and 2538 from obesity to merit a story in a newspaper, compared with 0.375 deaths from measles, 1.5 from vCJD, and 22.5 from AIDS. However, in newspaper features pages it takes 173 alcohol related and 468 obesity related deaths to merit a story, compared with 0.12 deaths from measles, 0.38 from vCJD, and 6.16 from AIDS.

Health in the News: Risk, Reporting and Media Influence is based on an analysis of health related stories in three BBC programmes—*BBC News at Ten O'Clock*, *Newsnight*, and BBC Radio 5 Live—and three newspapers—the *Daily Mirror*, the *Daily Mail*, and the *Guardian*. It sought to ask three questions: to what extent did news coverage of health related issues reflect mortality risks shown in health data? If the balance of health news coverage was seriously out of proportion with actual risks to health, how much did that matter? And could and should anything be done about it?

The study looked at the BBC's health coverage from 10 September 2000 to 10 September 2001 and at the newspapers' health coverage from October to December 2002. (The researchers say that time and resources available governed the scale of the survey and that they selected a more recent time frame for the newspaper analysis "to provide a counterpoint to the BBC period.") The study found a preponderance of two kinds of stories—stories about NHS crises, such as growing waiting times or an increase in negligence cases, and health scares, which often involved little empirical impact on rates of illness and premature death.

The researchers also interviewed health experts and policy makers, and found that they were almost universally dissatisfied with how the news media covered health related matters. Interviewees felt that issues that posed minimal risks, such as the alleged link between MMR and autism, received too much prominence over proven health risks. While they broadly agreed that there could be no correlation between what conditions caused the most deaths and what received the most coverage, they felt that there should be more careful consideration on all sides about the balance of news reporting of health issues.

The report's authors, BBC radio correspondent Roger Harrabin, King's Fund health policy director Anna Coote, and freelance researcher Jessica Allen, say: "We are not interested simply in accusing the media of exaggeration or misrepresentation. Nor do we wish to suggest any simple causal link between patterns of reporting on the one hand and policy decisions and personal behaviour on the other."

Mr Harrabin, who carried out research for the report while on sabbatical from the BBC *Today* programme, says: "As journalists we need to give our audiences new news, not old news—but we shouldn't forget that policy makers are often influenced by what they see in the media. The public may also alter their behaviour in ways that affect their health because of information and advice they get from the media."

In the foreword to the report, Professor Siân Griffiths, president of the Faculty of Public Health Medicine, calls for more media coverage of the obesity epidemic or damage to health from alcohol or tobacco. "If the biggest risks to public health are scarcely mentioned in the news while stories about NHS waiting times or health scares such as the recent SARS [severe acute respiratory syndrome] virus—where health risks to UK health are minimal—regularly make the headlines, it is fair to ask whether the public interest is well served by the media."

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Health in the News: Risk, Reporting and Media Influence is available priced £8 from the King's Fund at www.kingsfund.org.uk/publications.

Next week's *BMJ* will be a special issue on how doctors communicate risk to patients

PERSONAL VIEW

The doctors' mess: the unsung resource

If we asked retiring doctors to look back over their careers to determine who or what had the most significant influence on their medical education, what do we think they would come up with? I expect that the most likely answers would be previous consultants and senior doctors, textbooks and teaching sessions, and experiences with memorable patients. Would anyone mention the doctors' mess?

The doctors' mess has always been associated with junior doctors hiding from work or eating their lunches. It is often a drab room, with the same facilities—usually a pool table, a drinks machine, and sometimes nowadays a computer, sofas (falling to pieces), and a satellite television (if you are lucky). The papers come every day, and most readers want the tabloids but pretend to be happy with the broadsheets. The washing up is never done by the doctors: either someone is employed who does it as part of their cleaning duties or it just isn't done. There is no panic if food or drink is spilled—no one worries about getting the stains out, and generally a solid rub into the carpet will do the trick.

There is, however, one other thing in every mess: doctors. The mess has always been a major point of social interaction for doctors. They come to talk about other staff they like or dislike, football, going out at the weekend, and, sometimes, politics. Something talked about probably more than anything else is medicine and all that relates to it. I know that when we were preregistration house officers my colleagues and I spent as much time as we could in the mess trying to be friendly with the senior house officers and registrars and asking them questions and being asked questions.

As my career progressed I found myself asking senior doctors in the mess about interview techniques, CVs, and which jobs to go for. I would also ask about difficult cases I had or aspects of a subject I didn't understand—"If you had a patient with low sodium what would you do?"—and so on. I can look back with fond memories on how I learned how to deal with chest pain, asthma, and other common illnesses, often in the mess with a registrar teaching me informally, maybe while watching the golf on television or playing pool. I recall talking with registrars about the membership examination of the Royal College of Physicians and various ways to learn for it and to pass it.

> The doctors' mess is an ever changing resource that updates itself continuously

I realised recently what an unsung resource the doctors' mess is—more accessible and easier to understand than a textbook, and definitely cheaper (£5 to £10 a month seems the going rate), and perhaps more approachable and available than a consultant. It is an ever changing resource that updates itself continuously. Now, as a specialist registrar I ask the other registrars about management in their specialty—"What happens to all these subarachnoid haemorrhages we refer to you neurosurgeons? Do all the patients get an operation, or what?" But more importantly I now find myself being asked the questions I used to ask: questions about ward management and about careers by the preregistration house officers and questions about the MRCP examination by the senior house officers. I congratulate people who use the mess in this way, probably without their realising it, and unreservedly recommend it to those who don't. It isn't just a dirty place at the end of the hospital.

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SOUNDINGS

Brava at Fountains

In August, during the heatwave, we went to our first open air opera. We had no idea what to expect. We had heard about *Aida* at Verona but this was *La Bohème* in Yorkshire. Would we be convinced that Mimi's tiny hand was frozen?

Fountains Abbey is a long way from a Parisian garret, but the opera's underlying theme, tuberculosis, was closer to home. In Haworth, a few miles away, Patrick Brontë had lost three of his children to consumption in a single year. Anne, Bramwell, and Emily were 29, 30, and 31 respectively. It must have been unbearable.

That was in 1849, the year that Henri Murger's novel, *Scènes de la Vie de Bohème,* was published. When Puccini adapted it for his opera nearly 50 years later, *Mycobacterium tuberculosis* had been identified, but effective drugs did not appear until my lifetime.

I was two years old when George Orwell died and as a child I remember people lowering their voices when mentioning "TB."

"In case of wet weather the event will go ahead," said the tickets, and sure enough there were canopies over the little stage and grand piano. And no microphones.

One audience member arrived in black tie, which he hastily removed, but most of us dressed for the dales. This, I realised, was Glastonbury for grown ups.

Everyone turned up early with a picnic. Most brought folding chairs and some had tables and tablecloths. Those of us with rugs were ushered to a groundsheet at the front.

Trying to look cool, I realised that I am no longer capable of lying down, drinking cava, looking up at the stage, and keeping control of my Scotch egg all at the same time. So it's chairs for us in future.

As the sun set, the walls of the famous ruin were picked out by floodlights and the grassy amphitheatre was dotted with the audience's lanterns. In the distance a baritone was warming up. An owl screeched in the nearby woods.

A page turner appeared and then a pianist in full evening dress. The small company, Opera Brava, was indeed totally convincing. Mimi sang her heart out and as she died in Rodolfo's arms, tears were running down my cheeks. Were they for her, the Brontës, Orwell, or victims everywhere? Hey, man, no. It was the music.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*